# FREEDOM OF CHOICE

Applicant's Name: _____ Date of Birth: _____

Representative (if any): _____

## SECTION I – FUNCTIONAL/MEDICAL ELIGIBILITY

Based on an assessment of functional abilities and needs conducted on _____ (*date*), the applicant indicated above:

☐ **Does** meet the functional/medical eligibility criteria for Medicaid LTC programs by scoring in Door _____.

☐ **Does Not** meet the functional/medical eligibility criteria for Medicaid NF Level of Care (please proceed to Section III)

| Signature of professional completing assessment | Title | Date |
|---|---|---|

## SECTION II - FREEDOM OF CHOICE

I have been advised that I meet functional/medical eligibility and have requested and received information about the following programs:

☐ MI Choice Program. I have received local referral information.

**Local Referrals:** _____

☐ Nursing facility care. I have received information about nursing facilities in my area.

☐ PACE Program. I have received information about the PACE program.

| Signature of applicant | Signature of applicant's representative | Date |
|---|---|---|

## SECTION III - APPEAL RIGHTS

I have received a copy of a denial of service based on this determination and understand my right to appeal.

| Signature of applicant | Signature of applicant's representative | Date |
|---|---|---|